AN ASSESSMENT OF THE

SAFETY NET *in Queens, New York*

Urgent Matters

The George Washington University Medical Center

School of Public Health and Health Services

Department of Health Policy

Acknowledgments

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The Northern Queens Health Coalition is a 60 member coalition of health services providers whose mission is to help providers and consumers identify gaps and inefficiencies in the health services delivery system. NQHC members include community-based providers of health and social services, faith-based organizations, ethnic community service groups, advocacy groups, disease-specific information and counseling organizations, hospice providers, libraries and cultural organizations, the Queen's Borough President's office, and small businesses.

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The Department of Health Policy is the home for health policy research and studies at the George Washington University Medical Center, School of Public Health and Health Services. The Department of Health Policy is dedicated to providing policymakers, public health officials, health care administrators, and advocates with the information and ideas they need to improve access to quality, affordable health care. This report and other *Urgent Matters* safety net assessments are available at the Department of Health Policy website www.gwhealthpolicy.org or the *Urgent Matters* website www.urgentmatters.org.

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Table of Contents

	Foreword	2
	Executive Summary	3
Section 1	The Health Care Safety Net in Queens, New York	6
	Introduction	6
	Background	8
	Structure of the Queens Health Care Safety Net	9
	Financing the Safety Net	12
Section 2	The Status of the Safety Net in Queens, New York: Challenges and Needs	15
Section 3	In Their Own Words: Results of Focus Group Meetings with Residents of Queens	20
Section 4	Emergent and Non-Emergent Care at Elmhurst Hospital Center's Emergency Department	23
Section 5	Improving Care for Uninsured and Underserved Residents of Queens	27
	Key Findings	27
	Issues for Consideration	28
Section 6	End Notes	29

Foreward

After several years of decline, the number of Americans without health insurance is climbing rapidly. Meanwhile erosion in tax revenues is driving states to cut funding for Medicaid. Both trends are hitting all health care providers hard, as they simultaneously attempt to cope with a nursing shortage, escalating labor costs, and the adoption of expensive new technologies.

These forces are felt the most in the health care safety net. These providers of care for the poor, uninsured and other vulnerable populations have not had to face such a confluence of challenges in recent memory. They must survive in an industry in upheaval, while attempting to serve the ballooning numbers of our fellow Americans in need. They must also continue to provide a set of highly specialized services, such as burn, trauma and neonatal care to a broad swath of their local communities.

It is against this backdrop that we have assessed the "state of the safety net" in Queens. Due to the foresight of the Robert Wood Johnson Foundation, a team of researchers at The George Washington University Medical Center led by Marsha Regenstein, PhD, MCP, has assessed the health of the safety net in ten United States communities. In each community we worked with a Community Partner—a local organization that helped us to identify the key issues and stakeholders. In Queens, we are deeply indebted to the Northern Queens Health Coalition. These community partners have also committed to convening opinion leaders and others in their region to discuss the implications of the reports' findings. All of this was done as part of the *Urgent Matters* project, a national program designed to spur awareness of safety net issues while finding practical ways to relieve one symptom of distress—crowded emergency departments.

Our goal is to provide new analysis and information on what is happening today in the critical systems of care for the underserved in these communities. By doing so we seek to inform the health care discussions in these places and the nation, and to lay a foundation for rational change and improvement. We do not presume to know all the answers. But we believe that an objective analysis by an unbiased team can be immensely helpful to communities in need of a critical analysis of their safety net. This report seeks to meet this need.

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Executive Summary

The *Urgent Matters* program is a new national initiative of the Robert Wood Johnson Foundation, designed to identify opportunities for relieving crowding in our nation's emergency departments and to improve access to quality care for uninsured and underserved community residents. *Urgent Matters* examines the interdependence between emergency department (ED) use and the health care safety net in ten communities throughout the United States. One component of this program was the development of comprehensive assessments of the safety nets in each of the ten communities that served as the focus of this study. This report presents the findings of the Queens, New York, safety net assessment.

Each of the *Urgent Matters* safety net assessments was prepared by a research team from The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, in close collaboration with the project staff from the hospitals selected for this study and a community partner. The Queens assessment draws upon information collected from interviews with senior leaders in the Queens health care community and from on-site visits of safety net facilities. The research team also met with key stakeholders in Queens as well as with residents who use safety net services.

To set the context for this study, the team drew upon secondary data sources to provide demographic information on the populations in Queens, as well as data on health services utilization, coverage statistics, and related information. The assessment includes an analysis of data that indicates the extent to which the emergency department at Elmhurst Hospital Center provides care that could be provided in a primary care setting.

This report examines key issues that shape the health care network available to uninsured and underserved residents in Queens. It provides background on the Queens health care safety net and describes key characteristics of the populations served by the safety net. It then outlines the structure of the safety net and funding mechanisms that support health care safety net services. The report also includes an analysis of key challenges facing providers of primary and specialty care services and specific barriers that some populations face in trying to access them.

Key Findings and Issues for Consideration: Improving Care for Uninsured and Underserved Residents of Queens

The safety net assessment team's analysis of the Queens safety net generated the following key findings:

The safety net in Queens consists of a complex arrangement of hospitals, clinics, and private physician's offices, located in a densely populated area that is one of the most ethnically, racially and linguistically diverse communities in the country. At the heart of the safety net is the Queens Health Network with two public hospitals—Elmhurst Hospital Center and Queens Hospital Center—and a total of 22 off-site ambulatory clinics, school-based health centers and school-based mental health programs. Three Federally Qualified Health Centers, including a clinic for homeless people, also offer care to the borough, and networks of private-practice physicians and community clinics care for the specific needs of different ethnic communities.

Primary, specialty, and hospital services exist in the Queens area, but new community residents and recent immigrants lack information about the availability of these services and find it difficult to navigate the system. Populations that are new to the borough may be unaware of the safety net facilities that will serve them, of insurance programs that will cover them and of the policies that allow them to be treated regardless of their ability to pay. Some groups are uncomfortable relying on government-sponsored programs such as Medicaid and choose instead to forgo care until absolutely necessary.

A significant percentage of emergency department visits at Elmhurst Hospital Center are for patients whose conditions are non-emergent. Over one-quarter (27 percent) of all emergency department encounters that did not result in an inpatient admission were for patients who presented with non-emergent conditions.

Despite serious efforts to serve all in need, safety net providers in Queens do not consistently provide care that is appropriately tailored to the needs of the ethnically diverse populations in the community. Elmhurst Hospital Center, the largest safety net provider in the northern Queens community, is not alone in its struggle to meet demand for interpreter services and culturally sensitive care. Primary care clinics rely heavily on bilingual staff to communicate with patients with limited English proficiency, but this strategy cannot adequately address the many languages spoken by the numerous ethnic groups in the borough. Safety net providers continue to face enormous challenges meeting the needs of various ethnic groups who bring very different sets of expectations to the health care encounter.

Many community residents feel more comfortable seeking services from primary care providers who are members of their ethnic community and who are more likely than traditional safety net providers to understand and respect their preferences for homeopathic or alternative therapies. Nonetheless, these residents often rely on larger safety net providers to access specialty and diagnostic services. The Queens Health Network has made great strides in linking community physicians with its network of specialty, ancillary and hospital services. But because of the diversity of the Queens community and the complexity of the safety net system, more collaboration is needed among community physicians and safety net providers to provide a fully integrated system of care.

Despite the network of care provided by the Queens Health Network, the mental health care system is not sufficiently robust to provide the necessary continuum of crisis and management services to uninsured and underserved patients. Gaps in care result in patients falling through the cracks, often not receiving timely assessments or appropriate treatment and follow-up care. In addition, demand for mental health services outpaces supply, further stressing an already stretched system.

Community- and faith-based organizations in Queens are actively involved in facilitating access to health care for uninsured and underserved residents. Initiatives include health fairs, health care seminars and outreach campaigns on important health issues. Efforts are underway to involve the ethnic media in highlighting the importance of health care for various groups of Queens residents, and community- and faith-based organizations are playing an important role in providing information on available resources.

The Urgent Matters *safety net assessment team offers the following issues for consideration:*

Safety net providers should look to the Queens Health Network as an example of how to successfully integrate primary and specialty services across sites of care. Improving collaboration and coordination of services among all safety net providers would go far to improve access for uninsured and underserved residents, particularly in immigrant populations.

Queens is a community of immigrants and its health care delivery system should speak directly to their needs and preferences. As challenging as this may be, local safety net providers must expand their interpreter services and outreach programs to improve patient encounters.

The health care community must work together to develop a patient education campaign to inform new immigrants about the services that are available in their communities. These providers should seek external sources of funding from public and private sources to underwrite a media campaign to bring the health care system closer to the everyday lives of Queens residents.

Community and faith-based organizations closely associated with ethnic communities can assist the efforts of safety net providers by providing meaningful linkages between the formal safety net and local private-practice physicians. Many physicians who are closest to immigrant communities do not work in tandem with health and social services to round out care for residents in need. The Queens Health Network has established a program that successfully links community physicians with its services. Outside of this system, however, stronger linkages are needed to improve access for underserved residents.

All local hospitals providing care to the uninsured and underserved in Queens may want to consider conducting focus groups or surveys to determine why patients choose ED care when other options are available. Through this type of research, community groups and hospital leaders could learn about the preferences and practices of patients who use the emergency department. Understanding the factors that drive ED demand could help residents find alternative sources of care and result in better outcomes for patients and providers alike.

The health care community should work together to build on the Queens Health Network's existing mental health care network in an effort to improve coordination of care with the primary care system. Primary care providers should be capable of assessing basic mental health problems and providing preventive care when appropriate. PCPs should also be aware of mental health providers in Queens and refer patients to them. The mental health providers need to improve follow-up and management services as well to ensure that patients with chronic conditions are receiving appropriate medical and social support. Hiring case managers and investing in community outpatient programs would help meet this need.

All hospitals in the Queens safety net should conduct analyses of the use of their emergency departments for emergent and non-emergent care. Such studies would help determine whether area hospitals are experiencing ED-use trends that are similar to those seen in safety net hospitals. Hospitals, community providers and other stakeholders should use the results of these studies to develop strategies for reducing crowding in the EDs.

Introduction

In 2000, the Institute of Medicine (IOM) published a report on the health care system serving uninsured and underserved individuals in the United States. Entitled *America's Health Care Safety Net: Intact but Endangered,* the report examined the viability of the safety net in the context of major changes in the financing and delivery of health care. The IOM report concluded that the safety net in America is under significant pressure from changing political and financial forces, including the growth in the number of uninsured in this country, the reduction or elimination of subsidies funding charity care, and the growth of mandated managed care.

The Robert Wood Johnson Foundation established the *Urgent Matters* program in 2002 to further study the dynamics of the health care safety net. While the IOM report focused its review principally on ambulatory and primary care settings, the *Urgent Matters* program takes IOM's research a step further and examines the interdependence between the emergency department (ED)—another critical component of the safety net—and core safety net providers who "organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients."[1]

The purpose of *Urgent Matters* is to identify opportunities for relieving crowding in our nation's emergency departments and to improve access to quality care for uninsured and underserved community residents. The program consists of three key components: 1) technical assistance to ten hospitals whose EDs serve as critical access points for uninsured and underserved patients; 2) demonstration grants to four of these ten hospitals to support innovative and creative solutions to patient flow problems in the ED; and 3) assessments of the safety nets in each of the communities that are home to the ten hospitals.

The purpose of Urgent Matters *is to identify opportunities for relieving crowding in our nation's emergency departments and to improve access to quality care for uninsured and underserved community residents.*

This report presents the findings of the safety net assessment in Queens, New York. Queens is a large and complex community with unique health care concerns relating to the incredible diversity of its residents. These issues add to the challenge of conducting a safety net assessment for the area. Our goal with the Queens report was to describe the availability of principal safety net providers in the borough and to identify areas where care could be improved for the uninsured and underserved. The assessment is not an inventory of safety net services in Queens, nor is it a comprehensive examination of patient problems.

Each of the *Urgent Matters* safety net assessments has been prepared by researchers at The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, in close collaboration with the hospital ED project staff and a community partner—an organization that is well-positioned to convene key stakeholders in the community to work together to strengthen safety net services on behalf of community residents. The *Urgent Matters* grantee hospitals and community partners are listed on the back cover of this report.

These assessments have been developed to provide information to communities about the residents who are most likely to rely on safety net services. They are designed to highlight key issues affecting access to care for uninsured and underserved residents, as well as to identify potential opportunities for improvement.

The assessments were conducted over the summer and fall of 2003. Each assessment draws upon information obtained through multiple sources. The Queens assessment team conducted a site visit on June 25-27, 2003, touring safety net facilities and speaking with numerous contacts identified by the community

partner and others. During the site visit, the community partner convened a meeting of key stakeholders who were briefed on the *Urgent Matters* project, the safety net assessment, and the key issues under review. This meeting was held on June 27, 2003 at Queens Borough Hall.

Through the site visits and a series of telephone conferences held prior to and following the visit to Queens, the assessment team interviewed many local informants, including senior leaders at hospitals and health systems, community health centers and other clinics, public health and other service agencies and mental health agencies. Individual providers or provider groups, advocates, and policymakers were interviewed as well. The team also drew upon secondary data sources to provide demographic information on the populations in Queens as well as data on health services utilization and coverage.

While in Queens, we conducted focus groups with residents who use safety net services. We held three groups with a total of 27 participants; one of the focus groups was conducted in English, one in Spanish, and one in Cantonese. The assessment team worked with the community partner to identify local organizations willing to assist with organizing and hosting focus groups, and recruiting patients who were likely to use safety net services.

The assessment included an application of an ED profiling algorithm to emergency department data from Elmhurst Hospital Center. The algorithm classifies ED encounters as either emergent or non-emergent cases. Like many other emergency departments across the country, Elmhurst Hospital is providing emergent care to patients who may not have emergent conditions.

Section one of the Queens safety net assessment provides a context for the report, presenting background demographics on Queens and New York State. It further describes the structure of the safety net, identifying the providers and facilities that play key roles in delivering care to the underserved. Section one also outlines the financial mechanisms that support safety net services. Section two discusses the status of the safety net in Queens based on the site visits, telephone conferences and in-person interviews. This section examines challenges to the safety net, highlighting problems in access to needed services, growing burdens on hospital emergency departments, stresses on safety net providers, declining rates of insurance coverage, and other barriers to care faced by the underserved.

Section three presents findings from the focus groups and provides insights into the challenges that uninsured and underserved residents face when trying to access services from the local health system. Section four includes an analysis of patient visits to the emergency department at Elmhurst Hospital. This analysis includes demographic information on patients who use the emergency department and examines the extent to which the emergency department at Elmhurst Hospital may be providing care that could safely be provided in a primary care setting. Finally, Section five presents key findings and issues that safety net providers and others in the Queens area may want to consider as they work together to improve care for uninsured and underserved residents in their communities.

Background

New York's Queens borough is home to over 2.2 million people.[2] The borough is densely populated (20,409 persons per square mile) with one of the largest immigrant populations in the country (see Table 1).[3] Over 46 percent of Queens' residents, more than twice the percent seen in the general population of New York State, are foreign born.[4]

Ethnically, the county is more diverse than the state. Just under half of Queens' residents are white, compared to 70 percent of the state's residents. One quarter of borough residents are Latino, one-fifth are black, and another fifth are Asian. Over half of the residents of Queens speak a language other than English at home.[5]

Table 1 A Snapshot of Queens County and New York

	Queens	New York State
Population (2001)		
Size	2.2 million	18.6 million
Density: persons/square mile	20,409	402
Race		
White	49.6%	70.2%
Black	21.2%	16.3%
Asian	21.3%	6.5%
American Indian/Alaska Native	0.4%	0.3%
Other	7.5%	6.7%
Latino origin and race	26.0%	16.1%
Language		
Foreign born	46.6%	20.9%
Language other than English spoken at home	53.1%	27.4%
Age		
18 years and over	77.4%	75.3%
65 years and over	12.4%	12.5%
Median age (in years)	35.8	36.5
Income and Poverty		
Living below poverty	12.2%	13.1%
Median household income	$44,233	$44.923
Insurance Coverage		
Commercial	50.7%=	55.2%#
Medicare	12.6%=	13.6%#
Medicaid and SCHIP	15.4%=	15.4%#
Uninsured	21.3%=	15.8%#

Source: American Community Survey Profile, 2002, U.S. Census Bureau, unless otherwise noted.
= REACH Data, 2000, National Association of Community Health Centers.
 # Annual Demographic Survey: March Supplement data, 2003, Current Population Survey.

One in five residents in Queens is without health insurance, a figure that outpaces the state by 35 percent.[6] The percentage is also likely an underestimate because of the number of undocumented immigrants in the borough. Over 15 percent of residents have Medicaid coverage and 12.6 percent are on Medicare.[7] Median household income for the borough is about $44,233, and over 12 percent of the area's residents lived in households with family incomes below the federal poverty level.[8]

Structure of the Queens Health Care Safety Net

The health care safety net in Queens consists of a complex network of hospitals, clinics and private physicians' offices. At the heart of the safety net is the Queens Health Network with an extensive network of hospital, specialty and ambulatory care. Three Federally Qualified Health Centers (FQHCs),[9] including one part-time FQHC homeless center, supplement the care provided by the hospitals and clinics. In addition, networks of private-practice physicians and private clinics serve different ethnic communities and are often used instead of, or in combination with, traditional safety net provider services.

Queens Health Network: The Health and Hospitals Corporation (HHC) is New York City's system of public hospitals. In Queens, HHC operates the Queens Health Network (QHN), which consists of two acute care facilities, Elmhurst and Queens Hospital Centers, and a number of community-based medical centers and practices,[10] school-based health centers and school-based mental health programs. The network also operates a number of ambulatory clinics geared specifically toward ethnic and minority patients and is a major provider of behavioral health and substance abuse services for the poor and uninsured. Elmhurst Hospital also has an on-site pharmacy, which is the only public hospital pharmacy that issues refills by mail.

Queens Health Network is the centerpiece of the safety net system in Queens with its extensive network of inpatient, ambulatory, emergency and community-based services. Combined, Elmhurst and Queens Hospitals have a catchment area that includes 1.6 million (72 percent) of Queens' 2.2 million residents. In total, the two hospitals had nearly 838,500 outpatient visits and over 200,000 emergency department visits in 2001.[11]

Elmhurst and Queens Hospital Centers also serve the greatest number of uninsured adult patients of all the hospitals in Queens.[12] Nineteen percent of Elmhurst Hospital's hospitalizations were uninsured/self pay patients in 2001 and 14 percent of Queens Hospital's hospitalizations were uninsured/self pay.[13] Elmhurst and Queens Hospitals also serve a large proportion of uninsured patients on an outpatient basis. Almost 40 percent of Elmhurst's outpatients are uninsured and 41 percent of Queens' outpatients are uninsured.[14]

Medicaid is the largest payer for hospitalizations at both of the Queens Health Network hospitals (56 percent for Elmhurst and 64 percent for Queens). Medicaid patients also represent a large percentage of outpatient visits for the two hospitals; at Elmhurst 42 percent of outpatient visits are covered by Medicaid and at Queens 38 percent are covered by the public insurance program.[15]

Other Hospitals: In Queens, a number of voluntary hospitals also contribute to the care of underserved patients. Jamaica Hospital Medical Center was identified as a key player in providing health services to the uninsured, while New York Medical Center of Queens serves a high proportion of Medicaid patients.[16] Other hospitals that serve an important role in the Queens safety net include two Saint Vincent Catholic Medical Centers—St. John's Queens Hospital Center and St. Joseph's Hospital—the North Shore University Hospital at Forest Hills, the North Shore Long Island Jewish Health System, and the Flushing Hospital Medical Center.

Primary and Preventive Care: The primary and preventive care system serving uninsured and underserved populations consists primarily of the 22 ambulatory clinics, including six school-based health centers operated by and associated with the Queens Health Network. Two FQHCs operate in the borough, located in the Far Rockaway and Jamaica neighborhoods. An FQHC homeless clinic also operates part-time out of the New York Hospital Medical Center of Queens. The North Shore Long Island Jewish Health System is working to open an FQHC in the Corona neighborhood of Queens. The health system targeted this neighborhood because of recent population growth in the area and the lack of primary care available to serve the residents. The health system has received the requisite Medically Underserved Area (MUA) designation for the community and is hopeful that a clinic will be open by the end of 2004.

Queens also has a number of clinics and programs in place to help its vulnerable, hard-to-reach populations

find health care. The Queens Health Network (QHN) has established four community-based, primary care clinics geared specifically toward immigrant and underserved groups in Queens. The QHN Women's Health Service at Corona provides services to a large Hispanic community by an all-female, Spanish speaking staff. Two Family Centers, Sunnyside Family Center and Springfield Gardens Family Center, were developed to address the unmet needs of the Mexican and Asian communities in West Queens and the black and Caribbean populations in South Queens, respectively. QHN also partnered with the Buddhist relief organization, the Tzu Chi Foundation, to open a new ambulatory clinic that will provide culturally sensitive services to Asian populations.

Physician and Hospital Supply: The physician supply in Queens lags behind that of the state (see Table 2).[17] There are 92.6 primary care providers per 100,000 patient population in Queens compared to 107.9 per 100,000 patient population in New York State. More notably, the borough has half the proportion of surgical specialists as the state and 35 percent fewer medical specialists. The county also has half the proportion of inpatient hospital beds as the state (1.60 per 1,000 patient population vs. 3.31, respectively) and fewer hospital admissions (70 per 1,000 patient population vs. 132, respectively).

Table 2 Physician and Hospital Supply, Queens County and New York

	Queens	New York State
Physician supply		
(per 100,000 patient population)*		
Primary care providers	92.6	107.9
Pediatricians	126.4	120.0
OB/GYN	26.4	39.9
Medical specialist	30.2	46.3
Surgical specialist	25.0	52.0
Hospital supply/utilization		
(per 1,000 patient population)		
Inpatient beds	1.60	3.31
Admissions	70	132
Emergency department visits	219	403

Source: Data are for 1999. Billings and Weinick. Monitoring the Health Care Safety Net Book II: A Data Book for States and Counties, Agency for Healthcare Research and Quality, 2003.

** Figures apply to 100,000 persons who would be the provider's patient population. Adult primary care providers represent the number of providers per 100,000 individuals 18 years of age and older; pediatricians represent the number of providers per 100,000 children age 17 and younger; ob/gyns represent the number of providers per 100,000 adult females.*

Specialty Care and Behavioral Health Services: QHN operates over 90 specialty clinics through its two hospitals and numerous ambulatory clinics. The FQHCs also provide some specialty care to their patients. The New York State Office of Mental Health, along with the New York City Department of Health and Mental Hygiene, coordinate and fund various behavioral health services in the city. These agencies oversee outpatient services, case management services and other community-level resources through contracts with voluntary and municipal hospitals, community-based mental health clinics, and residential and outreach service providers.

As the principal safety net provider in Queens, QHN offers a wide array of mental health services through its ambulatory care clinics and inpatient services, a mobile crisis unit, school-based programs and emergency services. Elmhurst Hospital Center supplements these efforts with a child/adolescent mental health walk-in clinic to which parents can bring children who are experiencing symptoms of mental illness. QHN provides a large volume of behavioral health care to residents of Queens with approximately 150,000 visits for these services annually.[18]

In addition, a network of voluntary agencies, including Steinway Family Services, Federation of Employment and Guidance Services (FEGS), Jewish Board of Family and Adult Services, and the Child Guidance Center, participate in the safety net and provide behavioral health services to the uninsured and underinsured. Local FQHCs also contribute to the mental health care of uninsured and underserved in the area with staff social workers who counsel patients with mental health issues and refer to area providers for serious mental health conditions.

For substance abuse programs, providers refer their patients to the J-CAP Foundation, Samaritan Village, Day Top, Counseling Services of EDNY, Elmcor, Outreach Project and Western Queens Alcohol Clinics. These programs operate residential, ambulatory and educational services. J-CAP also provides in-house care, primary care and outreach services for persons with HIV/AIDS. Patients in these programs are generally covered by Medicaid and receive support from the New York State Office of Alcoholism and Substance Abuse Services and the Department of Health.

Community-based Programs: HealthReach NY is a program dedicated to improving access to health care for uninsured residents of Queens. HealthReach NY, supported by The Robert Wood Johnson Foundation, is a non-profit organization that identifies private community physicians willing to donate their time and services to care for uninsured adults in Queens. The program also helps patients better understand the health care system and assists with setting up appointments and facilitating necessary ancillary services.

Approximately 120 primary care and specialty physicians participate in the HealthReach NY program and each see an average of two or three patients per week at no charge. Patients can usually get an appointment within eight weeks of the referral. HealthReach NY has also partnered with the Queens Health Network to provide ancillary and diagnostic services to HealthReach NY patients free of charge. Most patients participating in the program are undocumented immigrants.

A number of community- and faith-based organizations sponsor health fairs for immigrant populations to provide health education and basic services. These fairs target elderly, low-income, undocumented, uninsured and underinsured residents, and have become a source of primary care for these populations. For many residents, health fairs provide an accessible entry into the health care system.

Managed Care Enrollment Programs: A number of community-based organizations are also active in helping eligible Queens residents enroll in managed care insurance plans. The Queens Facilitated Enrollment Partnership, under the lead agency Safe Space, receives funding from the New York State Department of Health for this work. A collaboration of five organizations, the Partnership had enrolled 15,651 children and 5,423 adults for health coverage by the end of 2003. The program provides services to some of the hardest-to-reach communities in Queens.

The primary goal of the enrollment program is to educate and assist individuals and families in the selection of a primary care physician of choice prior to selecting a managed care organization. Once the individual or family begins to receive coverage, all follow-up services including re-certification are provided directly to the consumer by the managed care organization.

The Managed Care Consumer Assistance Program (MCCAP)[19] is a unique city program that helps low-income and minority New Yorkers navigate New York's complex health care system. MCCAP provides assistance to vulnerable New Yorkers, including those on Medicaid, Medicare, Family Health Plus, Child Health Plus, commercial insurance, and those without

insurance. New Yorkers in all five boroughs can seek aid through MCCAP's network of 22 community organizations. Five of these organizations provide services to consumers in Queens. Two of the largest of these programs are located onsite at Elmhurst and Queens Hospital Centers. The program helps residents obtain health coverage and educates them on how to use health insurance. Services are provided in 13 languages via consumer hotlines, educational workshops, and hands-on assistance to facilitate access to care.

Financing the Safety Net

Overview

New York finances its safety net system using a combination of public insurance programs and pool funding. The state's Medicaid and Child Health Plus programs provide subsidized health care coverage to individuals who would otherwise be uninsured. A Medicaid expansion program, Family Health Plus, and two other subsidy programs targeted at uninsured, working individuals, have greatly expanded the number of residents eligible for health insurance coverage. New York supplements these programs with an Indigent Care Pool (ICP) funding mechanism that helps hospitals and other safety net providers cover the costs of providing care to indigent populations. Federally qualified health centers are also eligible for ICP funding.

In support of these efforts, New York infused the health care system with $2.9 billion in additional financing in 2000 through the Health Care Reform Act (HCRA).[20] HCRA 2000 continued the negotiated rate system enacted in 1996, through which hospital rates are negotiated by hospitals and insurers rather than set by the state. The legislation also strengthened the state's pool funding mechanisms for uncompensated care at hospitals and health centers, eliminated cuts to Medicaid programs for three years following enactment of the act, funded a Medicaid expansion plan and created two new insurance programs, described below.[21] Funding came from a $0.55 increase in the state tax on cigarettes and approximately $1.5 billion in proceeds from New York State's tobacco lawsuit settlement.[22] In the FY 2004 state budget, the legislature preserves these funding streams through June 30, 2005.

Medicaid and Child Health Plus A[23]

Medicaid provides health insurance coverage to some low-income residents, including adults, seniors, persons with disabilities, and pregnant women. Child Health Plus A provides coverage to children who meet the income eligibility criteria of the Medicaid program. Eligibility categories are based on net income as a percent of poverty or a county's Standard of Need.[24,25] The state does not include certain assets (e.g., property owned) in its eligibility calculations, thereby extending eligibility to some families who would otherwise be ineligible for benefits.[26]

Child Health Plus A covers infants up to 200 percent of the federal poverty level (FPL) and children ages one to 19 up to 133 percent of the FPL.[27] Medicaid covers pregnant women with incomes up to 200 percent of the FPL, regardless of immigration status. Parents, disabled adults and 19-20 year olds are covered if they have incomes of up to 87 percent of the FPL and childless adults are covered if their incomes are 100 percent or less of the FPL. Legal immigrants with appropriate documentation are eligible for Medicaid; New York State does not require a five-year waiting period. Medicaid and Child Health Plus enrollment exceeded 2.6 million people in New York City in 2001.[28]

Medicaid provides coverage for federally-mandated services as well as a number of optional services. Benefits include inpatient and outpatient hospital services, doctor and clinic visits, prescription drugs, home health care, nursing home care, hospice care,

dental services, physical therapy, rehabilitative services and home and community-based waiver programs.[29] Through Child Health Plus A, children under the age of 21 are guaranteed all necessary screenings and treatment, as well as assistance with appointments and transportation.[30]

New York State provides funding at the institutional level through Bad Debt and Charity Care Pools (BDCC). The BDCC Pools cover a portion of the costs that safety net hospitals incur when providing care to low-income and uninsured patients. In 2001, Medicaid payments to these pools comprised 64 percent and 65 percent of Elmhurst and Queens Hospitals' total revenue, respectively.[31]

Emergency Medicaid

The Medicaid program also provides benefits for treatment of emergency medical conditions. This program, called Emergency Medicaid, is available to all individuals presenting in a hospital with an emergency, regardless of immigrant status, as long as they meet all other eligibility requirements. A physician must certify upon admission that a patient is in need of emergency care.

Family Health Plus

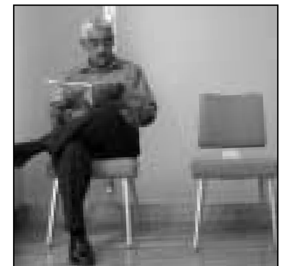
Family Health Plus (FHPlus), a Medicaid expansion program, was implemented to capture uninsured, working adults and parents whose children qualify for Child Health Plus B (described below). The point of the program was not only to expand eligibility, but also to simplify the application process in an effort to increase insurance rates. To that end, FHPlus implemented a streamlined application process and more lenient eligibility requirements. In addition, the program does not have co-payments, premiums or other types of cost-sharing mechanisms so as not to alienate potential enrollees. FHPlus is administered through managed care insurers.[32]

FHPlus provides comprehensive health coverage to uninsured, low-income adults who have incomes or assets above the New York Medicaid eligibility levels. FHPlus expands Medicaid to parents with incomes up to 150 percent of the federal poverty level and single adults and childless couples with incomes up to 100 percent of the FPL. Adults ages 19 to 64, with or without children, are eligible for FHPlus as long as: they are permanent residents of New York State; they are citizens or Medicaid-eligible qualified aliens;[33] they are not eligible for Medicaid; and they do not receive any equivalent health care coverage or insurance.[34]

Child Health Plus B

In 1991, New York State established Child Health Plus (CHPlus), a state-sponsored insurance program aimed at expanding health care coverage for children. CHPlus received federal SCHIP money under Title XXI in 1998 and further expanded children's insurance coverage in 1999 with a SCHIP waiver and an expansion of Medicaid.

Under SCHIP, New York expanded Medicaid coverage (CHPlus A) to children ages 15 to 18 with family incomes of up to 100 percent of the FPL and CHPlus B coverage to children up to age 19 with family incomes up to 250 percent of the FPL.[35] All children meeting these requirements are eligible, regardless of their immigration status. In 2002, CHPlus had extended coverage to over 250,000 children to reach a total of about 1.3 million publicly insured children in New York State.



Healthy New York

HCRA 2000 provided funding for The Healthy New York program in order to expand coverage to uninsured, working poor individuals in New York State. The program provides state-subsidized coverage for

FHPlus provides comprehensive coverage to uninsured, low-income adults who have incomes or assets above the New York Medicaid eligibility levels.

small employers and for individual workers. The standardized health insurance packages are available through all HMOs in New York and are available to businesses with 50 or fewer employees. Employers must have offered no employer-based coverage in the previous 12 months, have one third of employees making less than $30,000 per year and be willing to pay at least 50 percent of employee premiums. Individuals working for firms who do not provide health insurance benefits are eligible to purchase the packages directly if their incomes are below 250 percent of the FPL. Since its inception in January 2001, the Healthy New York program has served a total of 58,880 individuals.[36] As of December 2003, the program had a net enrollment of 39,661.[37]

Indigent Care Pools

In addition to its public insurance programs, New York State funds its safety net system through pool funding mechanisms called Indigent Care Pools (ICPs). These pools finance health care for uninsured New Yorkers in both hospitals and health centers.[38]

Hospital Indigent Care Pools

HCRA 2000 strengthened this funding stream with a private payer surcharge, a Medicaid surcharge and an assessment on hospital inpatient revenue.[39] The FY 2004 state budget increased the private payer surcharge from 8.18 percent to 8.85 percent and the Medicaid surcharge from 5.98 percent to 6.47 percent to help preserve the ICP funding stream. All hospitals receive funding from the ICPs, with safety net hospitals that treat higher numbers of indigent patients receiving larger amounts from the pools.

Following implementation of HCRA, the ICPs consisted of $738 million for the original uncompensated care pool, $82 million for a rural/high-need indigent care adjustment pool, and a $27 million supplemental indigent care payment designed to fund indigent care at teaching hospitals.[40] Queens' safety net hospitals have benefited most from the rural/high needs indigent care pool, which contains $36 million specifically earmarked for high-need, indigent care hospitals like Elmhurst and Queens Hospitals. All together, Elmhurst Hospital receives $50.2 million from ICPs per year and Queens receives $34.7 million.

Diagnostic and Treatment Indigent Care Pool

Article 28 Diagnostic and Treatment Centers (D&TCs)[41] also receive funding from the Indigent Care Pool. The D&T Indigent Care Pool provides $48 million annually to public and nonprofit comprehensive D&TCs to cover the cost of uncompensated care.[42] Clinics and FQHCs that provide care to a disproportionate number of indigent patients receive larger amounts from the pool, based on clinics' indigent care costs in 1996.

FQHC Funding

The three federally qualified health centers in Queens are financed through a combination of federal and state funds. The centers are eligible to receive some funding from the indigent care pool to cover the cost of uncompensated care. The FQHCs are also eligible for Section 330 federal funding from the Health Resources and Services Administration, and qualify for enhanced Medicaid and Medicare payments.

The safety net assessment team conducted interviews with key stakeholders in the Queens health care community and visited safety net facilities on June 25-27, 2003. The analysis of the Queens safety net was greatly informed by the interviews with safety net providers and other local stakeholders. Informants discussed important changes in local health policy and programs, emergency department use and crowding, issues related to access to care and significant barriers that patients face getting the care they need.

Overview

Despite a well-developed and well-funded safety net, pockets of great need still exist in Queens. Four communities consisting of a total of 19 neighborhoods clustering in the North/Northwest and the West/Southwest report having poor access to medical care despite the presence of major safety net providers.[43] In these areas and throughout the borough, specific patient groups, including the uninsured, working poor and undocumented are particularly underserved.[44]

Health care providers, community- and faith-based organizations, the ethnic media and the community at large have all embarked on efforts to educate patients and help them become more comfortable with the health care system. These efforts would be more successful, however, if the individuals involved worked together to coordinate their efforts and leverage their resources to gain the attention of the community.

Better Coordination among Safety Net Providers Needed

Cultural preferences dictate where some populations seek care. Some ethnic groups prefer to seek care from private-practice physicians or private clinics within their ethnic community rather than from hospital health centers or other public facilities. Patients seek out community-based practices because they feel more comfortable with doctors who speak their languages, understand their customs and are versed in the non-traditional medical remedies of their country.

Access to these providers, however, can be problematic for low-income, uninsured residents. Knowledge of their services is not widespread and is circulated primarily by word of mouth. Wait times for appointments with these providers can be long because demand is high. Moreover, many private physicians do not take Medicaid or uninsured patients, thereby eliminating an important source of culturally competent care for needy and underserved residents.

QHN has taken important steps to improve access to care by coordinating services between Elmhurst and Queens Hospitals and the community providers in the borough. For the past 10 years, QHN has managed a network of 550 community physicians and allied health professionals throughout Queens, in an effort to facilitate physician referrals, improve patient tracking and share consultation reports. Through the program, QHN manages over 1,400 referrals each month.[45] Over one fourth of these physicians are credentialed by QHN and many participate in the major managed care plans. The referral process is closely monitored by QHN in an effort to reduce patient misdirection.

Queens Health Network also operates clinics geared toward specific ethnic groups in an effort to better serve immigrant populations. Services at these clinics are provided on a sliding-fee scale.

HealthReach NY is another unique program dedicated to helping uninsured residents of Queens find appropriate health care free of charge. Demand for care, however, has outpaced supply and the program administrators are finding it increasingly difficult to find physicians, especially specialists, to participate in the program.

Shortages of Specialty Care Providers

Problems accessing specialty care in Queens center on the lack of providers serving Medicaid or uninsured patients. Elmhurst and Queens Hospitals both provide

Despite a well-developed and well-funded safety net, pockets of great need still exist in Queens.

a range of medical and surgical specialty care, and community-based providers often refer patients to QHN medical and surgical specialists. Waits for appointments, however, are long and not all specialties are represented. FQHCs also provide some specialty care, but the scope of their services is limited compared to that available at the hospitals. Patients often travel outside of the borough to get timely specialty care.

Dental care is also difficult for low-income, uninsured residents to obtain. Few providers will treat Medicaid patients and even fewer will take uninsured patients. Queens Hospital has a dental program that treats these populations, but wait times for appointments are long. As a result, many uninsured and underserved residents forgo care until a dental emergency arises and they seek treatment in the ED.

Gaps in Behavioral Health Care Services

Behavioral health services in Queens have expanded in the past few years with significant improvements in residential and community-based care. QHN is one of the principal providers of mental health services in the area, offering a wide range of services. QHN also provides a rigorous follow-up program to ensure that patients make and keep follow-up appointments after discharge from the hospital or ED.

Despite these services, demand outpaces supply in Queens and behavioral health agencies are at capacity, leaving many patients with unmet mental health care needs. Furthermore, outside of QHN, coordinated networks of mental health providers and community resources are hard to find in the borough. As a result, preventing patients from falling through cracks is a challenge, especially for special needs populations like the mentally ill and chemically addicted and patients recently released from prison.

Immigrants face additional barriers to getting behavioral health care. Efforts to ensure that this population has access to appropriate mental health care are further complicated by the cultural stigma attached to needing this type of care. In an effort to improve access to behavioral health care for immigrants, Elmhurst Hospital operates a Hispanic and Asian mental health program for both ambulatory and hospital patients. In addition, a number of other mental health agencies specialize in ethnic and cultural patient populations, including the Puerto Rican Family Institute, the Child Guidance Center and the Hellenic American Action Committee. Despite these efforts, many immigrants will not seek out care at all or will only seek care outside of the borough.

Use of Emergency Departments for Non-Emergent Conditions

No single factor can explain the frequent use of the emergency department for care that could safely be provided in a primary care setting. Patient perceptions of ED care and access barriers to primary care both play a role in increasing use.

Convenience plays a large part in patients' decisions to use the ED as their primary source of care. Patients are willing to wait because they know they will leave the ED having received comprehensive care. Patients seeking care at a clinic or FQHC are likely to need to return on another day or make multiple appointments for tests or treatments. In addition, the ED is open 24 hours a day with comprehensive services, while the hours and services of individual providers or community clinics are limited. The community's perception of the quality of care received in an ED also influences patients' preferences. Patients believe the ED offers the most current technology, which instills confidence and encourages use.

ED use also occurs because of the many barriers uninsured and underserved patients face when seeking out primary care. The uninsured often cannot afford alternative primary and preventive care options, or are unaware of providers who offer care for free or for reduced fees. In addition, cultural differences are often in play when health is an issue. Some cultures will defer care until their non-emergent condition becomes emergent.

Enrollment in Medicaid Coverage Lagging

Despite the state's strong commitment to providing health care coverage to its low-income populations, close to 20 percent of Queens residents are uninsured. Some of these individuals may be eligible for Medicaid or other public insurance programs, but are either unaware of their eligibility status, confused by the application process or uncomfortable relying on a government-sponsored program for care. Still others are undocumented and ineligible for the programs.

New York has made an effort to improve application processes for its Medicaid programs, particularly Family Health Plus, to capture larger numbers of eligible candidates. FHPlus implemented a streamlined eligibility and enrollment process and does not require asset or resource tests, making it easier to apply. Furthermore, the governor and state legislature have pledged to maintain funding of the programs supported by the Health Care Reform Act through June 30, 2005. The continued support can help improve enrollment in New York's public insurance programs, but the results of these efforts are not yet known.

A Lesson Learned: Disaster Relief Medicaid

Before September 11, 2001, enrollment in public insurance programs in New York City was declining. The programs covered not only fewer people, but a decreasing percentage of those in the lowest income brackets.[46] Non-financial eligibility criteria such as citizenship or immigration status, coupled with a complicated enrollment process, kept many people in need from receiving Medicaid coverage.

In response to the terrorist attacks of September 11, 2001, the city implemented Disaster Relief Medicaid (DRM), an emergency insurance program designed to expand and expedite the enrollment process for residents who potentially could be eligible for benefits. Income eligibility levels for DRM reflected those that had been approved for Family Health Plus, but not yet implemented. This income expansion made many more New Yorkers eligible for coverage. Damage to New York City's Medicaid computer system required that DRM use a simplified and expedited application process consisting of a one-page form and verbal attestation to income level rather than formal documentation of proof. Applicants often received coverage on the day they applied.[47]

Disaster Relief Medicaid enrolled almost 350,000 people in four months, increasing Medicaid caseloads to pre-welfare reform levels.[48] Many of these applicants were immigrants, who otherwise had no access point into health insurance programs available to other residents in New York. DRM enrollees received Medicaid for six to eight months. Enrollees were contacted shortly before their coverage was due to expire, and encouraged to stay in the program by applying through the standard procedures with documentation requirements.[49]

DRM played an important role in the New York City safety net by serving as a point of entry into the health care system for many residents who had previously confronted barriers. Some DRM enrollees reapplied for traditional Medicaid coverage, giving them continued coverage for health care. Others used DRM for its short-term benefits, getting needed care while it lasted. Both documented and undocumented immigrants used DRM to obtain care they could not otherwise have afforded. Furthermore, other New York programs have adopted many of DRM's more flexible rules and procedures to further expand insurance coverage in the city. Higher eligibility income levels have been implemented in FHPlus, and legal, resident immigrants are now eligible for FHPlus and regular Medicaid.

Unfortunately, DRM proved to be only a short-term fix, as many enrollees lost coverage when required to enroll in Medicaid or FHPlus through standard procedures. Some residents who were eligible found the re-enrollment process daunting and were uncertain how to proceed.[50]

Other Barriers to Care

Cultural barriers, documentation issues, logistical problems and lack of insurance all pose significant problems for low-income residents trying to obtain health care.

Language Barriers and Cultural Competency: Because of the ethnic diversity in Queens, language and cultural obstacles are among the most significant barriers to care for residents. Over half the residents in Queens speak a language other than English at home and approximately 39 language classifications were documented by the 2000 Census, covering the several hundred languages spoken throughout the county.[51]

Hospitals in the borough use a combination of services to address the language needs of immigrant populations, including full-time interpreting staff, bilingual providers and staff, and a telephonic interpreter service. Because the cost of interpreters is high, clinics rely mostly on bilingual staff and the language line for interpreting. Overall, these efforts are too limited to meet the overwhelming diversity of languages spoken in Queens. Wait times for appointments with providers who provide high quality interpreter services are especially long.

The importance of culturally sensitive health care cannot be understated in Queens. The inability to provide this type of care is as significant an obstacle as the language barrier. Health care facilities, however, have a difficult time knowing and understanding the customs of so many cultures. Cultural preferences can present barriers to getting care for both documented and undocumented immigrants. Some ethnic groups are reluctant to discuss private health care issues and, as a result, put off care until an emergency situation arises. Other ethnic groups delay care because they feel uncomfortable discussing their financial situation with strangers. Still others are more comfortable with non-western traditions of care, declining to use the U.S. system unless absolutely necessary.[52] Creating and enhancing programs that are culturally sensitive and tailored to the needs of this large and diverse population remains an important long-term challenge for local safety net providers.

Documentation Requirements: For immigrants who are undocumented, the fear that their status will be revealed is an added barrier to obtaining health care. To assuage these concerns, the president of the Health and Hospitals Corporation of New York recently reaffirmed the corporation's policy that all information related to a patient's immigration status is strictly confidential and may not be disclosed to any third party. The policy alone, however, does not completely remove the barrier that undocumented immigrants might perceive, even if unwarranted. Immigrants may be unaware or distrustful of the confidentiality rule and, consequently, avoid contact with medical facilities unless absolutely necessary.

Difficulty navigating the health care system: Navigating the health care system is a challenge, particularly for new immigrants or for patients with limited English proficiency or limited formal education. While ample services are available in Queens, the network is somewhat fragmented, wait times can be long and many components of the system are unfamiliar to residents. Both hospitals in the Queens Health Network are well known in the community, but residents may be less aware of QHN's numerous ambulatory clinics or the FQHCs in the community.[53]

Even residents who are aware of the services available in Queens face challenges trying to work their way through the system.[54] Informants reported that patients in the borough must sometimes see three or four providers before getting comprehensive and appropriate diagnostic, treatment and follow-up care. Informants noted that follow-up care is especially difficult to obtain because patients are sometimes misdirected to inappropriate facilities and waiting periods for appointments are long. Time between assessment and follow-up are also obstacles that discourage patients from getting appropriate care.

The Queens Health Network has put significant effort into alleviating these navigation issues. QHN has implemented an e-record system that eliminates the need for paper files and reduces the possibility of lost patient information. The electronic record system integrates clinical information, lab results, radiology

records and medication orders, and links the hospitals with their satellite facilities. The referral process between QHN and other community providers is closely monitored to help patients navigate the system and to reduce problems of misdirection of care. QHN has also worked hard to reduce appointment cycle times (the duration of time from a patient's entry for an appointment to his/her exit) to improve patients' primary care experiences. The network has undergone a rigorous ambulatory care redesign in an effort to reduce delays.

Lack of insurance and cost of care: Despite New York State's efforts to expand health care coverage for needy populations, lack of insurance is a huge barrier to care for the residents of Queens. As in any community, insurance status determines when and where a patient gets care and the quality of the care received. More than one in five residents in Queens is uninsured. Many of these residents are eligible for coverage, but simply lack the ability to enroll. There are many reasons why they are not enrolled—they cannot take time off from work to go to the enrollment office; they do not know where to go to enroll; they do not understand the application process; or they do not have all the necessary paperwork to complete enrollment. For immigrants with limited English proficiency, navigating the enrollment process is even more difficult. These obstacles are compounded by the requirement that enrollees must reapply for benefits every year. The cost of health care without insurance, however, is high and well beyond the ability of most uninsured patients to pay. Even with insurance the cost of co-payments can be a significant disincentive to seeking care.

The safety net assessment team conducted focus groups with residents who receive their care from safety net providers in the Queens area. The focus groups were held on September 23 and 24, 2003, at three locations in the Queens area. These locations were Elmhurst Hospital Center, The Charles B. Wang Community Health Center, and LaGuardia Community College. Focus group participation was voluntary. Participants were recruited with the help of local community organizations, which displayed flyers announcing the sessions and their schedules. Participants received $25 each in appreciation of their time and candor. A total of 27 individuals participated in the focus groups. One group was conducted in Cantonese, one in English, and one in Spanish.

The focus group discussions highlighted the difficulties that many uninsured and underserved residents have in accessing timely and affordable health care in Queens. Participants addressed issues such as primary care and prevention, access to specialty and inpatient services, their use of the ED for emergent as well as non-emergent care, their understanding of the health care system and the opportunities that are available to them, and their feelings about the provider community.

General Impressions

Almost all participants said they had experienced some obstacle to getting care, including long wait times at clinics and in the ED, language barriers, difficulties finding in-plan specialists, and general problems navigating the health care system. The magnitude of problems that participants faced seemed to depend on their knowledge about and familiarity with safety net providers, as well as their understanding of health insurance coverage, billing procedures, referral mechanisms and appointment policies.

Participants' experiences seemed to vary by ethnicity, as well. The Cantonese-speaking participants, most of whom were uninsured, had little information regarding resources available to them. They also indicated a greater reluctance to access the health care system. The Spanish and English-speaking participants, most of whom were immigrants, seemed to have better connections with the health care safety net, though they also felt greater frustration with barriers such as waiting periods and lack of coverage.

Participants who were less aware of the resources available to them ... were frustrated with their experiences.

The focus group participants underscored the need for information and education about the safety net system in Queens. In general, the more familiar they were with the health care system (primarily with Elmhurst Hospital Center and its network of clinics), the happier they were with their experiences accessing care. Participants who were less aware of the resources available to them were much less comfortable navigating the system and frustrated with their experiences.

Elmhurst Hospital and the Safety Net in Queens

Opinions about Elmhurst Hospital varied significantly across the three groups. The Spanish-speaking group, who used Elmhurst as their primary source of care, was very loyal to the hospital. For many, Elmhurst was their first and only choice for health care. One participant noted that the care at Elmhurst is "like heaven" compared to health care from his home country. Most of these participants were familiar with Elmhurst's procedures, and had a level of comfort with the health care system that participants in the other two groups did not have. Many had been consistently receiving care from the hospital for years. These participants were also more patient with wait times, noting that a lot of patients need care and that the quality of care is worth waiting for.

Participants in the English-speaking group, however, expressed frustration with their experiences at Elmhurst, noting long wait times and uneven treatment by hospital staff. In general, these participants did not seem to use Elmhurst as their primary source of care, but rather as a place to go in an emergency. The participants

seemed less attached to the health care system and less familiar with its procedures.

Most participants seemed to feel that the greatest barriers to their accessing primary care were wait times and finding convenient providers in their plans.[55] Some participants used Elmhurst as their provider for primary care and, even given the option of getting care from an Elmhurst satellite clinic, preferred to see physicians at the main hospital site. Those who were not as familiar with the hospital, such as the Cantonese-speaking participants, said they would rather see private physicians in their communities for primary care, particularly if they speak their language and are culturally sensitive. Some of these participants were unaware of Elmhurst's primary care clinics and sliding fee scales.

Access Barriers

Lack of coverage was cited as the most significant barrier to care by participants in the Cantonese-speaking group. Only two participants were insured and, although a number of participants worked, none received insurance through the workplace. Much of the discussion centered on the expense of purchasing individual health insurance and on participants' reluctance to rely on government-sponsored programs. One individual noted that her greatest health concern is her lack of insurance; with coverage, she noted, she would be able to find a Chinese-speaking physician.

Without insurance, participants said they end up paying out-of-pocket for their health care. Instead of using fee-scaled clinics or the ED, however, many said they either put off care or seek care from herbalists or other non-traditional providers. One participant said she relies on herbal remedies because they are less expensive. Another added that traditional prescription drugs are much more expensive than Chinese herbs, because of the added cost of the physician visit to get the prescription.

Health insurance was not as huge an issue with the English- and Spanish-speaking groups as with the Chinese-speaking group. Many more Latino and non-immigrant participants had Medicaid coverage than did Chinese participants. Many participants with Medicaid said they had enrolled in the program through Elmhurst Hospital after going there for care.

Navigating the Health Care System

Difficulty navigating the health care system was also a huge barrier to care for a number of participants, especially some of the Latino individuals. One woman who had recently been admitted to the hospital said she had had a difficult time understanding who to talk to and where to go, particularly when she was trying to deal with her hospital bill. "It's like a web," trying to figure out how the process works, she said. Others agreed that the insurance eligibility and financial screening process at large hospitals is very confusing and often not conducted with respect, especially for patients with limited English proficiency. In response to these problems, one participant noted she would rather pay out-of-pocket for a private doctor than try to navigate the system at a large hospital. Some participants suggested that smaller community hospitals, while not as convenient, may be easier to navigate.

General lack of knowledge of the health care system in Queens was also a major barrier for the Chinese-speaking group. Most were unaware that they could receive care at a hospital emergency department regardless of insurance or immigration status and none was aware of the primary care clinics or the subsidized pharmacy available to them through the Queens Health Network. None of these participants had ever been to an emergency department in Queens or other parts of New York.

Wait Times

Among the Spanish- and English-speaking groups, waiting for care was the most common problem mentioned by participants. Almost all had had to wait for care at some point either at an emergency department or a clinic.[56] Many noted that even patients with appointments must often wait all day before getting care. One participant noted that patients often do not know, and are not told, that they need appointments for care, which prolongs wait periods. For example, he was told to get follow-up care at a clinic, but was not told he needed an appointment. As a result, he lost a day of work waiting for an appointment. Participants further reported that,

when they do schedule appointments, they can wait up to three months before finally getting in to see a primary care doctor. Such long waits create incentives for going to the ED instead of a primary care clinic.

Language Barriers

Language issues seemed to be particularly problematic for the Chinese-speaking participants. The Spanish-speaking participants felt they either knew enough English to communicate with their doctors or their doctors knew enough Spanish to communicate with them. One participant said he had recently had a positive experience with Elmhurst's telephone interpreter line, using the service with his physician for over an hour. On the other hand, Chinese participants cited language barriers as a disincentive for seeking care. One woman noted that she is "scared" to go to the hospital because she does not speak English. While a number of Chinese physicians practice in Queens, they can be expensive to see unless patients have insurance. Most of the Chinese participants said they use friends or family members as interpreters. This practice can be burdensome to those who must take time off from work to help with the appointment.

Specialty Care

Participants had mixed reviews regarding ease of access to specialty care. In general, those more familiar with Elmhurst's network felt that accessing specialty care was not a major problem. One participant noted that wait periods can be shorter for some specialties than for primary care. Some participants said they are quite willing to wait, since they know that the quality of the care they receive is first-rate. Some participants said the quality of care and the overall treatment they had received from their specialists was excellent and better than the care they had received from some primary care physicians.

Other focus group participants said that wait times are usually long to see specialists and that it is difficult to find specialists in convenient locations who participate in Medicaid HMOs. Language barriers can make it even more difficult to find a specialist. The Chinese participants noted that it is easy to find Chinese physicians in the community for some of the more common specialties such as ophthalmology, but difficult to find providers for others such as rheumatology. One participant said she must regularly travel to Manhattan to see her specialist.

A number of people noted that wait times at the subsidized pharmacy in Elmhurst were a serious problem. Some participants, however, appreciated the availability of free or subsidized drugs and said they understand that these services are heavily used.

Outreach and Information

In general, participants said they wanted more information about how the health care system works in New York and about the network of safety net providers in Queens. Many were unaware of important resources that could facilitate getting care, such as health insurance enrollment offices or subsidized pharmacies. Some individuals suggested promoting these types of services in community media outlets, such as Chinese-language newspapers or Spanish television. Others suggested doing outreach in community-based organizations such as schools, faith-based organizations, or libraries. Still others said more information at the hospitals or doctors' offices regarding treatment plans and follow-up would be helpful.

Overview

The emergency department plays a critical role in the safety net of every community. It frequently serves as the safety net's "safety net," serving residents who have nowhere else to go for timely care. Residents often choose the ED as their primary source of care, knowing they will receive comprehensive, quality care in a single visit. When and why residents use the emergency department depends largely on patients' perceptions of the quality of care in hospital EDs, primary care providers' willingness to see low-income, uninsured populations, and the accessibility of timely care outside of the ED. Whether it serves as a first choice or last chance source of care, the ED provides a valuable and irreplaceable service for all community residents, including low-income, underserved populations.

Problems arise, however, when using the ED leads to crowding and ambulance diversion. When the ED is too crowded, quality of care and patient safety can be compromised. Many factors cause of crowding, including limited inpatient capacity, staff shortages, physicians' unwillingness to take call, and increased demand for services from uninsured as well as insured patients. It is important to focus on all these issues when trying to address the problem.

In this section of the report, we provide an analysis of ED use at Elmhurst Hospital. Using a profiling algorithm,[57] we were able to classify visits as either emergent or non-emergent. We were able to further identify what portion of those visits were primary care treatable, preventable/avoidable or non-preventable/non-avoidable. Communities should use this information to further understand the dynamics of health care delivery. These data, however, do not tell the whole story and should not be viewed as a comprehensive analysis of emergency department use in the community.

The ED Use Profiling Algorithm

In 1999, John Billings and his colleagues at New York University developed an *emergency department use profiling algorithm* that creates an opportunity to analyze ED visits according to several important categories.[58] The algorithm was developed after reviewing thousands of ED records and uses a patient's primary diagnosis at the time of discharge from the ED to apportion visits to five distinct categories. These categories are:

1) Non-emergent, primary care treatable
2) Emergent, primary care treatable
3) Emergent, preventable/avoidable
4) Emergent, non-preventable/non-avoidable
5) Other visits not classified according to emergent or non-emergent status

According to the algorithm, ED visits are classified as either emergent or non-emergent. Emergent visits are ones that require contact with the medical system within 12 hours.

Emergent visits are further classified as either needing ED care or treatable in a primary care setting. Visits classified as "primary care treatable" are ones that could have been safely provided in a setting other than an ED. These types of visits are ones that generally do not require sophisticated or high-tech procedures or resources (such as CAT scans or certain laboratory tests).

Visits that are classified as needing ED care are classified as either non-preventable/non-avoidable or preventable/avoidable. The ability to identify visits that would fall in the latter category may offer opportunities to reduce costs and improve health outcomes: patients who present with emergent but preventable/avoidable conditions should be treated earlier and in settings other than the ED.

A significant percentage of visits remain unclassified by the algorithm in terms of emergent status. Visits with a primary ED discharge diagnosis of injury, mental health

Residents often choose the ED as their primary source of care, knowing they will receive comprehensive, quality care in a single visit.

and substance abuse, certain pregnancy-related visits and other smaller incidence categories are not assigned to algorithm classifications of interest.

The data from the ED utilization category must be interpreted cautiously and are best viewed as an indication of utilization rather than a definitive assessment. This is because the algorithm categorizes only a portion of visits and does not include any visits that result in an inpatient admission. For many hospitals, visits that result in an inpatient admission are not available in ED electronic databases. Presumably, since these visits warrant inpatient treatment, none would fall into the non-emergent category. Excluding these visits may inflate the primary care treatable (both emergent and non-emergent) categories. Since a sizeable percentage of ED visits remain unclassified, percentages or visits that are classified as falling into one of the four emergent or non-emergent categories may understate or overstate the true values in the population.

ED Use at Elmhurst Hospital Center

The Elmhurst Hospital emergency department comprises three discrete sets of emergency services: adult, pediatric, and psychiatric. Most ED visits occur in the adult and pediatric EDs (94 percent); only a small portion of visits take place in the psychiatric ED. The three EDs have different patient populations and also differ in terms of insurance coverage. Nearly half (46 percent) of adult ED visits are for uninsured patients and one quarter (25.6 percent) are for patients covered by Medicaid. Only one tenth of pediatric visits are for uninsured patients and seven out of 10 (69.4 percent) are for patients covered by Medicaid. An additional 12 percent of pediatric ED visits are for patients covered by Child Health Plus. In the psychiatric ED, one third of the visits are for Medicaid-covered patients and a comparable percentage (36.5 percent) are for uninsured patients.

As part of the *Urgent Matters* safety net assessment process, we collected information on ED visits at Elmhurst Hospital Center for the period July 1 through December 31, 2002. During that six-month period, there were 50,894 ED visits that did not result in an inpatient admission. There were an additional 9,023 ED visits for the six-month period that resulted in an inpatient admission and 20 visits were missing a diagnosis code. Table 3 provides information on these visits by race, coverage, age and gender.

Table 3 Demographic Characteristics of ED Visits

Race		Coverage		Age		Gender	
Asian	11.3%	Commercial	8.3%	0-17	45.2%	Female	48.4%
Black	7.8%	Medicaid	43.3%	18-64	50.5%	Male	51.6%
White	8.8%	Medicare	3.7%	65+	4.3%		
Latino	62.6%	Uninsured	32.5%				
S Asian/Mid East	4.2%	Other	12.1%				
Other/unknown	5.3%						

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy analysis of ED data provided by Elmhurst Hospital's emergency department.

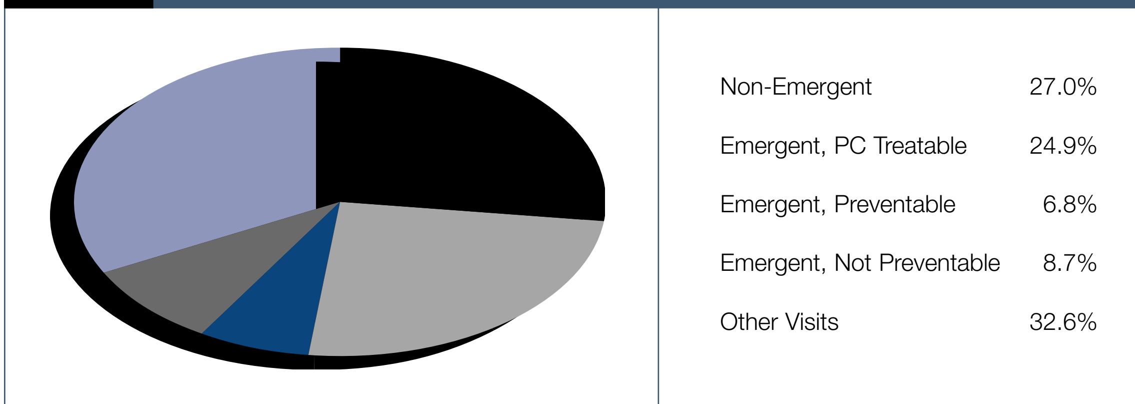
Key Demographic Characteristics of ED Visits

Over 60 percent of ED visits at Elmhurst were for patients who are Latino or Hispanic. Another 15 percent of visits were for Asian, South Asian or Middle Eastern patients.

One-third of visits to Elmhurst were for patients who were uninsured. Only 3.7 percent of patient visits were covered by Medicare.

Over 45 percent of all ED visits were for patients under 18 years of age.

Figure 1 Visits by Emergent and Non-Emergent Categories



Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy application of the ED use profiling Algorithm to data provided by Elmhurst Hospital's emergency department.
Note: Data from ED encounters that resulted in hospital admission not included in algorithm.

The analysis using the ED algorithm shows that a significant percentage of visits to Elmhurst's ED could have been treated in settings other than the ED. As Figure 1 demonstrates, 27 percent of ED visits at Elmhurst were non-emergent and another 25 percent were emergent but primary care treatable. Thus more than half of all ED visits that did not result in an inpatient admission could have been safely treated outside of the ED.

Table 4 compares the rate of visits that were emergent, that required ED care, and that were not preventable or avoidable against rates for other categories of visits. For every visit that was in the emergent, not preventable category, there were three non-emergent visits and almost three more emergent but primary care treatable visits.

These findings differ across various categories. Patients on Medicare were less likely to seek treatment in the ED for non-emergent conditions than were participants in other insurance categories. Yet even for Medicare patients, visits for non-emergent conditions occurred at twice the rate of emergent, non-preventable visits. According to the analysis, patients who were commercially insured had nearly the same rates of use of the ED for non-emergent conditions as patients who were uninsured.[59] It is important to note that these findings refer to the allocation of visits across emergent and non-emergent categories and do not address whether uninsured patients, per se, use the ED in greater numbers than insured patients. This assessment would not be possible in the absence of better data on ED use across many more hospitals in the Queens area to determine whether uninsured patients were using ED care at higher rates than insured patients.

Differences are also seen across payer categories in the rates for emergent, primary care treatable visits. Among uninsured patients, for every visit that occurred for emergent, non-preventable conditions, there were about two visits for emergent, primary care treatable conditions. For patients on Medicaid, there were 3.74 emergent, primary care treatable visits to every one emergent, non-preventable visit. The high rate common to the Medicaid population is at least in part a result of the large percentage of children who seek care at Elmhurst's ED.

Patients with commercial insurance were as likely to use the ED for primary care treatable conditions as patients in the other payer categories. Rates of primary care treatable visits for commercially insured patients fell between Medicaid and uninsured patient rates with 2.42 primary care treatable visits for every one non-preventable visit.

Children used the ED for non-emergent and emergent, primary care treatable conditions at much higher rates

Table 4 Relative Rates for ED Visits at Elmhurst Hospital Center

	Non-Emergent	Emergent, Primary Care Treatable	Emergent, ED Care Needed Preventable/ Avoidable	Emergent, ED Care Needed Not Preventable/ Not Avoidable
Total	**3.09**	**2.85**	**0.78**	**1.00**
Insurance Status				
Commercial	2.64	2.42	0.77	1.00
Medicaid	3.36	3.74	1.02	1.00
Medicare	2.01	1.48	0.60	1.00
Uninsured	2.75	2.07	0.51	1.00
Age				
0-17	4.50	4.99	1.35	1.00
18-64	2.40	1.78	0.49	1.00
65+	2.10	1.51	0.47	1.00
Race				
Asian	2.86	2.75	0.71	1.00
Black	2.76	2.33	1.00	1.00
Latino	3.24	2.99	0.78	1.00
White	2.52	1.80	0.64	1.00
S. Asian/ Middle Eastern	3.28	3.83	0.95	1.00
Sex				
Female	2.93	2.82	0.71	1.00
Male	3.27	2.80	0.86	1.00

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy application of the ED use profiling algorithm to data provided by Elmhurst Hospital's emergency department.

than did patients in other age categories.[60] For children, there were 4.5 non-emergent and 5 emergent, primary care treatable visits to every one emergent, non-preventable visit.

The use of the ED for non-emergent care was high, regardless of the race or ethnicity of the patient group. White patients had lower rates of ED use for emergent, primary care treatable conditions—a category for which use was particularly high among South Asian and Middle Eastern patients.

Many fewer visits were classified as emergent but preventable or avoidable compared to all other categories. The algorithm does not provide sufficient detail to determine why these visits tended to be lower than those in the emergent, non-preventable category.

These data support the assertion that some patients are using the ED at Elmhurst Hospital Center for conditions that could be treated by primary care providers. This suggests that there are opportunities to improve care for patients in Queens while also addressing crowding in the ED at Elmhurst Hospital Center. While this analysis does not address ED utilization at other hospitals in Queens, these findings are similar to other analyses of large urban ED populations and are likely to be similar to patterns at other hospitals in the area.

Key Findings

After examining the important components of the Queens safety net, the assessment team identified the following key findings:

The safety net in Queens consists of a complex arrangement of hospitals, clinics, and private physician's offices, located in a densely populated area that is one of the most ethnically, racially and linguistically diverse communities in the country. At the heart of the safety net is the Queens Health Network with two public hospitals—Elmhurst Hospital Center and Queens Hospital Center—and a total of 22 off-site ambulatory clinics, school-based health centers and school-based mental health programs. Three Federally Qualified Health Centers, including a clinic for homeless people, also offer care to the borough, and networks of private-practice physicians and community clinics care for the specific needs of different ethnic communities.

Primary, specialty, and hospital services exist in the Queens area, but new community residents and recent immigrants lack information about the availability of these services and find it difficult to navigate the system. Populations that are new to the borough may be unaware of the safety net facilities that will serve them, of insurance programs that will cover them and of the policies that allow them to be treated regardless of their ability to pay. Some groups are uncomfortable relying on government-sponsored programs such as Medicaid and choose instead to forgo care until absolutely necessary.

A significant percentage of emergency department visits at Elmhurst Hospital Center are for patients whose conditions are non-emergent. Over one-quarter (27 percent) of all emergency department encounters that did not result in an inpatient admission were for patients who presented with non-emergent conditions.

Despite serious efforts to serve all in need, safety net providers in Queens do not consistently provide care that is appropriately tailored to the needs of the ethnically diverse populations in the community. Elmhurst Hospital Center, the largest safety net provider in the northern Queens community, is not alone in its struggle to meet demand for interpreter services and culturally sensitive care. Primary care clinics rely heavily on bilingual staff to communicate with patients with limited English proficiency, but this strategy cannot adequately address the many languages spoken by the numerous ethnic groups in the borough. Safety net providers continue to face enormous challenges meeting the needs of various ethnic groups who bring very different sets of expectations to the health care encounter.

Many community residents feel more comfortable seeking services from primary care providers who are members of their ethnic community and who are more likely than traditional safety net providers to understand and respect their preferences for homeopathic or alternative therapies. Nonetheless, these residents often rely on larger safety net providers to access specialty and diagnostic services. The Queens Health Network has made great strides in linking community physicians with its network of specialty, ancillary and hospital services. But because of the diversity of the Queens community and the complexity of the safety net system, more collaboration is needed among community physicians and safety net providers to provide a fully integrated system of care.

Despite the network of care provided by the Queens Health Network, the mental health care system is not sufficiently robust to provide the necessary continuum of crisis and management services to uninsured and underserved patients. Gaps in care result in patients falling through the cracks, often not receiving timely assessments or appropriate treatment and follow-up care. In addition, demand for mental health services outpaces supply, further stressing an already stretched system.

Community- and faith-based organizations in Queens are actively involved in facilitating access to health care for uninsured and underserved residents. Initiatives include health fairs, health care seminars and outreach campaigns on important health issues. Efforts are underway to involve the ethnic media in highlighting the importance of health care for various groups of Queens residents, and community- and faith-based organizations are playing an important role in providing information on available resources.

Issues for Consideration

The *Urgent Matters* safety net assessment team offers the following issues for consideration:

Safety net providers should look to the Queens Health Network as an example of how to successfully integrate primary and specialty services across sites of care. Improving collaboration and coordination of services among all safety net providers would go far to improve access for uninsured and underserved residents, particularly in immigrant populations.

Queens is a community of immigrants and its health care delivery system should speak directly to their needs and preferences. As challenging as this may be, local safety net providers must expand their interpreter services and outreach programs to improve patient encounters.

The health care community must work together to develop a patient education campaign to inform new immigrants about the services that are available in their communities. These providers should seek external sources of funding from public and private sources to underwrite a media campaign to bring the health care system closer to the everyday lives of Queens residents.

Community and faith-based organizations closely associated with ethnic communities can assist the efforts of safety net providers by providing meaningful linkages between the formal safety net and local private-practice physicians. Many physicians who are closest to immigrant communities do not work in tandem with health and social services to round out care for residents in need. The Queens Health Network has established a program that successfully links community physicians with its services. Outside of this system, however, stronger linkages are needed to improve access for underserved residents.

All local hospitals providing care to the uninsured and underserved in Queens may want to consider conducting focus groups or surveys to determine why patients choose ED care when other options are available. Through this type of research, community groups and hospital leaders could learn about the preferences and practices of patients who use the emergency department. Understanding the factors that drive ED demand could help residents find alternative sources of care and result in better outcomes for patients and providers alike.

The health care community should work together to build on the Queens Health Network's existing mental health care network in an effort to improve coordination of care with the primary care system. Primary care providers should be capable of assessing basic mental health problems and providing preventive care when appropriate. PCPs should also be aware of mental health providers in Queens and refer patients to them. The mental health providers need to improve follow-up and management services as well to ensure that patients with chronic conditions are receiving appropriate medical and social support. Hiring case managers and investing in community outpatient programs would help meet this need.

All hospitals in the Queens safety net should conduct analyses of the use of their emergency departments for emergent and non-emergent care. Such studies would help determine whether area hospitals are experiencing ED-use trends that are similar to those seen in safety net hospitals. Hospitals, community providers and other stakeholders should use the results of these studies to develop strategies for reducing crowding in the EDs.

1 Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered* (Washington, DC: National Academy Press, 2000): 21.

2 Demographic and economic statistics were calculated using data from the 2002 American Community Survey, a project of the U.S. Census Bureau. The ACS is a sample survey subject to sampling variability. It has a 90 percent confidence interval. The ACS universe includes only household populations and excludes populations living in institutions, college dormitories and other group quarters. See U.S. Census Bureau, *American Community Survey Profile 2002: New York City Queens County, Profile of General Demographic, Social and Economic Characteristics* (Washington, DC: U.S. Census Bureau, 2003), www.census.gov/acs/www/Products/Profiles/Single/2002/ACS/index.htm

3 U.S. Census Bureau, *Profile of General Demographic Characteristics 2000: Queens County New York* (Washington, DC: U.S. Census Bureau, 2000), http://factfinder.census.gov

4 2002 American Community Survey.

5 Ibid.

6 National Association of Community Health Centers, Resources to Expand Access to Community Health (REACH) Data 2000 (Bethesda, MD: NACHC, 2002). The REACH data are based on Census Bureau data and provide estimates on the number of persons by poverty level, age, gender, race, and primary sources of health insurance for each county in the U.S. in 2000. Estimates are based on the 2000-2002 pooled data from the Census Population Survey and the 2000 Census of the United States which are provided by the Bureau of Census.

7 Ibid.

8 2002 American Community Survey.

9 Federally Qualified Health Centers (FQHCs) are designated to serve medically underserved populations. FQHCs are eligible for Section 330 grants from the Health Resources and Services Administration (HRSA) to offset the costs of care to uninsured patients. They also are eligible for enhanced Medicaid reimbursements.

10 Queens Health Network's community-based medical centers and practices are health clinics that partner with or are operated by Elmhurst and Queens Hospitals. Some of these facilities offer services provided by private-practice physicians and use a private-practice model of care.

11 Singer I, Davison l, Fagnani L. 2003. *America's Safety Net Hospitals and Health Systems, 2001: Results of the 2001 Annual NAPH Member Survey.* Washington, DC: National Association of Public Hospitals and Health Systems.

12 United Hospital Fund. 2002. *New York City Community Health Atlas, 2002*. New York City: United Hospital Fund.

13 Singer, et al.

14 Ibid.

15 Ibid.

16 United Hospital Fund, 2002.

17 J. Billings, and R. Weinick, *Monitoring the Health Care Safety Net Book II: A Data Book for States and Counties* (Washington, DC: Agency for Healthcare Research and Quality, 2003).

18 Personal communications with interviewees. Interviews were held between summer 2003 and winter 2004.

19 The MCCAP was established in 1998 as a City Council initiative in recognition of the challenges many New Yorkers face as more and more people receive their health care through managed care organizations. The Community Service Society of New York operates the program with funds from the Department of Health and Mental Hygiene.

20 HCRA's $2.9 billion funding stream was used to strengthen a variety of health care resources, for commercially insured, publicly insured and uninsured residents. A significant portion of the funds was used to bolster safety net Programs, including the Indigent Care Pool, Medicaid, Family Health Plus, and Healthy New York.

21 HCRA also created a mechanism to target individuals who purchase their own health insurance. Through this HCRA measure, known as direct pay subsidies, HMOs are eligible to receive reimbursement for 90 percent of HMO-paid claims between $20,000 and $100,000 for members who are individual enrollees. For additional information on this program, see Health Care Association of New York, *Health Care Reform Act of 2000: Briefing Paper* (New York, NY: Health Care Association of New York, 2000).

22 Health Care Association of New York, *Health Care Reform Act of 2000.*

23 Child Health Plus A is New York State's Medicaid program for children; all children in the state who are enrolled in Medicaid are in Child Health Plus A. Child Health Plus B is an expansion program implemented by the State in 1991 to reach greater numbers of uninsured children. Children Health Plus B became the state's CHIP program and is currently funded under Title XXI.

24 In New York City, the Standard of Need criterion is significantly lower than the criteria set by percentage of poverty level. Therefore, all income eligibility categories will be outlined in terms of FPL.

25 D.Holahan, M. Cordova, K. Haslanger, M. Birnbaum, E. Elise Hubert, *Health Insurance Coverage in New York, 2001* (New York, NY: United Hospital Fund, 2003).

26 K. Thorpe, C. Florence, *Medicaid Eligible, But Uninsured: The New York State Experience* (New York, NY: United Hospital Fund, 2000).

27 In 2003, the FPL was $8,980 for an individual and $18,400 for a family of four (U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2003).

28 Holahan, et al., *Health Insurance Coverage in New York, 2001.*

29 Healthcare Association of New York State, *New York State's Medicaid Program: A Sound Approach to Care* (Rensselaer, NY: Healthcare Association of New York State, 2003).

30 New York City Department of Health and Mental Hygiene health insurance brochure, www.nyc.gov (2003).

31 Medicaid net revenues include base Medicaid payments and Medicaid DSH payments. See: Singer, et al.

32 Health Care Association of New York, *Health Care Reform Act of 2000: Briefing Paper* (New York, NY: Health Care Association of New York, 2000).

33 Legal immigrants with appropriate documentation are eligible for Medicaid in New York State without a five-year waiting period.

34 Criteria downloaded from http://www.health.state.ny.us/nysdoh/fhplus/summary.htm

35 A.W. Lutzky, J. Holahan, J. Weiner, R. Bovbjerg, N. Brennan, B. Bruen, J. Chesky, T. Coughlin, I. Hill, S. Kendall, S. Long, B. Ormond, M.B. Pohl, J. Tilly, F. Ullman, A. Wigton, A. Yemane, and S. Zuckerman, *Health Policy for Low-Income People: Profiles of 13 States* (Washington, DC: Urban Institute, 2002).

36 The Lewin Group, *Report on the Healthy NY Program 2003* (New York, NY: New York State Insurance Department, 31 December 2003), www.ins.state.ny.us/acrobat/hnylewin.pdf (as of February 2004).

37 Net enrollment is defined as new enrollees less disenrollees. See: The Lewin Group, 2003.

38 In addition to these sources of funding, New York City subsidizes Elmhurst Hospital's parent company, Health and Hospitals Corporation, to help cover a portion of its operating expenses.

39 Health Care Association of New York, *Health Care Reform Act of 2000: Briefing Paper* (New York, NY: Health Care Association of New York, 2000).

40 Ibid.

41 Under Article 28 of the New York Public Health Law, community health centers are licensed as diagnostic and treatment centers (D&TCs) and designated under New York Department of Health regulations as comprehensive facilities offering both primary and preventive care to a full range of patient populations. D&TCs include FQHC and look-alikes, community clinics and hospital-sponsored clinics. See Community Health Care Association of New York, *Quality Health Care at an Affordable Price: New York's Community Health Centers* (New York, NY: Community Health Care Association of New York, 2002).

42 Community Health Care Association of New York, *Quality Health Care at an Affordable Price: New York's Community Health Centers.*

43 New York City Department of Health and Mental Hygiene, *Community Health Profiles* (New York, NY: New York City Department of Health and Mental Hygiene, 2003).

44 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

45 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

46 K. Haslanger, J. Tallon, D. Gould, D. Holahan, M. Cordova, *Redrawing the Line: The Changing Shape of New York's Health Insurance Crisis* (New York, NY: United Hospital Fund, 2002).

47 M. Perry, *New York's Disaster Relief Medicaid: Insights and Implications for Covering Low-Income People* (New York, NY: United Hospital Fund, 2002).

48 Haslanger, et al., *Redrawing the Line: The Changing Shape of New York's Health Insurance Crisis.*

49 Ibid.

50 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

51 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

52 Elmhurst has implemented a number of initiatives to improve cultural and linguistic access issues. The hospital has hired a senior administrator to focus exclusively on these problems and has instituted an interpreter training program for bilingual staff. Elmhurst also offers language classes to its monolingual staff. In addition, the hospital has established a number of committees, outreach initiatives and public forums to improve cultural appropriateness in the provision of health care.

53 Personal communications with interviewees. Interviews were held between summer 2003 and winter 2004.

54 Coordinated health care is a benefit experienced mostly by insured patients. Unfortunately, fragmented networks are far too common in safety net systems and among providers who serve the uninsured and underserved. A number of the *Urgent Matters* safety net sites suffer from this problem. Some, however, have made it a priority to provide comprehensive, coordinated care to these populations.

55 The majority of participants were either uninsured or covered by Medicaid; many had been uninsured, on Medicaid or covered by commercial plans at different points in time.

56 Representatives from Elmhurst Hospital Center do not believe that focus group participants' sentiments on wait times accurately reflect service delivery at their sites of care.

57 The algorithm presented here uses a methodology that has been replicated in numerous communities in the country to categorize emergency department visits data. The algorithm does not address the issue of appropriate use of the ED for non-emergent and/or primary care treatable conditions. This issue has been discussed extensively in the peer-reviewed literature. For a summary of these discussions see: L. Richardson and U. Hwang, "Access to Care: A Review of the Emergency Medicine Literature," *Academic Emergency Medicine* 8, no. 11 (2001) 1030-1036.

58 For a discussion of the development of the algorithm and the potential implications of its findings, see J. Billings, N. Parikh and T. Mijanovich, *Emergency Room Use: The New York Story* (New York, NY: The Commonwealth Fund, November 2000).

59 This finding is consistent with recent research showing increases in the numbers of commercially insured patients relying on emergency departments for care. See P. J. Cunningham and J.H. May, *Insured Americans Drive Surge in Emergency Department Visits,* Issue Brief 70 (Washington, DC: Center for Studying Health Systems Change, 2003).

60 Children often use the ED for non-emergent care at higher rates than patients in other age categories. These findings are seen in several of the *Urgent Matters* ED use profiling analyses.

Urgent Matters Grantee Hospitals and Community Partners

Atlanta, Georgia
Community Partner: National Center for Primary Care, Morehouse School of Medicine
Project Director: George Rust, MD, MPH FAAFP
Grantee Hospital: Grady Health System
Project Director: Leon Haley, Jr., MD, MHSA, FACEP

Boston, Massachusetts
Community Partner: Health Care for All
Project Director: Marcia Hams
Grantee Hospital: Boston Medical Center
Project Director: John Chessare, MD, MPH

Detroit, Michigan
Community Partner: Voices of Detroit Initiative
Project Director: Lucille Smith
Grantee Hospital: Henry Ford Health System
Project Director: William Schramm

Fairfax County, Virginia
Community Partner: Fairfax County Community Access Program
Project Director: Elita Christiansen
Grantee Hospital: Inova Fairfax Hospital
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Community Partner: Community Health Endowment of Lincoln
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Grantee Hospital: BryanLGH Medical Center
Project Director: Ruth Radenslaben, RN

Memphis, Tennessee
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Project Director: Alicia M. McClary, EdD
Grantee Hospital: The Regional Medical Center at Memphis
Project Director: Rhonda Nelson, RN

Phoenix, Arizona
Community Partner: St. Luke's Health Initiatives
Project Director: Jill Rissi
Grantee Hospital: St. Joseph's Hospital and Medical Center
Project Director: Julie Ward, RN, MSN

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Community Partner: Northern Queens Health Coalition
Project Director: Mala Desai
Grantee Hospital: Elmhurst Hospital Center
Project Director: Stuart Kessler, MD

San Antonio, Texas
Community Partner: Greater San Antonio Hospital Council
Project Director: William Rasco
Grantee Hospital: University Health System
Project Director: David Hnatow, MD

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Project Director: Kristin Garrett, MPH
Grantee Hospital: University of California at San Diego
Project Director: Theodore C. Chan, MD